Commonwealth of Massachusetts
Executive Office of Health and Human Services

Chapter 257 of the Acts of 2008 Report

CHAPTER 257 IMPLEMENTATION REPORT
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This document serves as the December 2010 report regarding the status of implementation of Chapter 257 of the Acts of 2008.

> *SECTION 170 of Chapter 131 of the Acts of 2010 reads: The executive office of health and human services shall report to the general court on the implementation of chapter 257 of the acts of 2008. The report shall include: (i) current rates for social service programs under section 22N of chapter 7 of the General Laws; (ii) the status of implementation of the prospective rate system established in said chapter 257; (iii) the process for establishing rates for social service programs, including inflation and geographic cost adjustments pursuant to section 2A of chapter 118G of the General Laws; (iv) the extent to which implementation of said chapter 257 has addressed the concerns raised in the executive office of health and human services report dated October 2007, entitled Financial Health of Providers in the Massachusetts Human Service System; and (v) initiatives undertaken to promote efficiency or to reduce or control costs and the results thereof. The executive office shall submit its report to the clerks of the house and senate, the house and senate who shall forward the same to the committees on ways and means, the joint committee on health care financing and the joint committee on children, families and persons with disabilities on or before December 1, 2010.*

EOHHS is submitting this report in response to Section 170.

I. Executive Summary

The Executive Office of Health and Human Services (EOHHS) and its agencies rely on a network of 1,100 health and human service provider organizations contracted to deliver care and support to more than one million Commonwealth residents through the Purchase of Service (POS) system. Across all departments the "POS system" is a $2.15B investment in services to children and families, services to adults with developmental disabilities, elder services, transitional assistance, and a range of other human services.

The need to reform the POS system is clear. Historically, EOHHS purchasing departments have negotiated reimbursement rates for human and social services on a program or contract basis, often in a non-standard manner and with limited cross-department coordination. As such, the POS system currently consists of thousands of individually negotiated contracts between departments and providers. Rates of reimbursement have not always been based on a uniform analysis of costs for services with core similarities and often are not adjusted to account for reasonable changes in costs over the term of the procurement.

In 2008, the General Court enacted Chapter 257 of the Acts of 2008, which places authority for the determination of reimbursement rates for social service programs with EOHHS and requires the consideration of the following criteria when setting and reviewing reimbursement rates:

- Reasonable costs incurred by efficiently and economically operated providers;
- Reasonable costs to providers of any existing or new governmental mandate;
- Changes in costs associated with the delivery of services (e.g. inflation impact);
- Substantial geographic differences in the costs of service delivery.

EOHHS has engaged in intensive efforts to implement Chapter 257 since its passage. Today, over a dozen Chapter 257 rate development projects are underway and are in various stages of completion. In Section IV of this report, EOHHS presents a discussion of the types of challenges experienced in current Chapter 257 rate development projects.

Three major challenges include:

- **Data Availability.** Comprehensive information on POS program costs and services is limited. As an audited, institutionalized form of annual cost report, the Uniform Financial Report (UFR) is one source of information available to support rate development although the UFR was not designed for this purpose. Given the limitations of this data, EOHHS supplements the UFR with other sources of information. The UFR must be modified in order to adequately support rate determination under Chapter 257.
- **Budget Impact.** When pricing analyses warrant overall reimbursement rate increases, additional funding is needed or service volume may need to be reduced.
- **Historical Variation.** In many cases reimbursement rates are the result of long-term contracts and individual negotiations between purchasing departments and providers. This has resulted in wide variation in rates that is not "explained" by identifiable differences in programs. Standardizing on cost-based rates in these cases may result in significant increases or decrease in revenue for many providers.

The final section of this report describes the options that EOHHS is considering to address these challenges. These options, which EOHHS and its stakeholders may pursue, include implementation of rate regulations with delayed effective dates, promulgation of regulations that provide for transition-to-target phase in periods, and filing legislation to modify the Chapter 257 timeline to align it with the Commonwealth budget cycle and procurement activity. Selection of any of these options must balance the need to meet the requirements of a range of other critical secretariat mandates while advancing Chapter 257 implementation goals.

II. Cost Savings Initiatives and Process for Establishing Rates

Chapter 257 presents a significant opportunity to reform not only the approach to reimbursement rate determination, but also to streamline procurement and contract management. Both can be done in a way that will improve the quality of services and the efficiency of the overall POS contracting process. Benefits of this comprehensive approach include increased transparency and consistency in rate setting practices, predictability and standardization in the thousands of individually negotiated contracts, better coordination among departments purchasing similar services, greater contract amendment flexibility, increased opportunities for provider engagement and input, and streamlining procurement cycles through central management.

To implement rate regulation EOHHS is pursuing three strategies:

- Group POS services by similarity into cross-Secretariat Service Classes organized in a new POS Classification System;

- Develop rational methodologies for setting payment rates for POS contracts;
- Reform POS contracting through wider use of streamlined, cross-Secretariat Master Agreement procurements and contracts.

For additional background on the Patrick-Murray Administration's Purchase of Service reform effort, Chapter 257, and EOHHS' approach to implementing the law, readers should refer to the previous EOHHS publications on the law. These, along with a range of other information on the current Chapter 257 rate development projects underway are located at www.mass.gov/hhs/Chapter257.

APPROACH TO RATE DEVELOPMENT

For all services under rate regulation, EOHHS reviews existing pricing methodologies, gathers input from providers and departments, and conducts analyses of existing cost and utilization changes to existing rates or proposed new rates. The following factors are considered in all Chapter 257 rate-setting projects:

Wages

Direct Care staffing is typically the major cost driver in any POS program, and differences in these costs often explain most of the variation in current reimbursement among programs. Wages are a significant component of Direct Care staffing costs, along with tax and fringe rates and client to staff ratios.

Generally, benchmark wages are derived from a baseline calculation of current averages for different categories of staff based on qualification and function using available representative data, which include UFRs and contract budgets. Purchasing departments may benchmark wages at above-average levels if current averages are inadequate. For departments purchasing new services, analysis focuses on wage data for comparable services and positions as well as departmental input regarding suitable wages based on intended staff qualifications, responsibilities and program structure.

To date, EOHHS has not developed a standard wage schedule across services. The primary reason is that staff qualifications and responsibilities often differ substantially across services within the same general staff category and position titles. For example, Direct Care staff operating in community settings and interacting with clients, their families and other service providers may require different qualifications than a Direct Care staff operating in a relatively closed 24/7 group home environment. Some wage standardization may be considered in the future after initial cycles of rate regulation and a "re-basing" of the POS system.

Tax and Fringe

A program's tax and fringe costs are another factor affecting total staffing costs. The tax and fringe costs are expressed as a percentage of wages. If wages are on the lower end of the spectrum, the percent can appear high relative to cost, since the cost of certain benefits, such as health insurance, does not vary depending on salary levels. Variation in tax and fringe rates can also reflect programmatic driven variables such as higher instances of Workers Compensation in some programs. Contract and UFR data do not specify types of benefits included in tax and fringe costs and which positions are covered.

Client to Staff Ratios
Client to staff ratios, a measure of staffing intensity, is an additional determinant of total staffing costs. A client to staff ratio of 10:1 indicates that for every 10 clients, there is one Full Time Equivalent (FTE) staff . This could be one full-time employee or, for example, two half-time employees. The closer the ratio is to 1:1, the more intensive and the more costly staffing costs are compared to lower intensity services that have comparable staffing qualifications.

Purchasers and/or licensing requirements frequently drive staffing ratios. In the absence of licensing or program policy requirements, the baseline for client to staff ratios are calculated from average staff ratios. From this analysis, multiple rates with different staffing ratio benchmarks may be necessary to reflect variation in client acuity, for example, or the economies of scale larger programs are able to enjoy.

Staffing Relief
Relief factors are another variable that can affect total direct care staffing costs and are most commonly applied in 24/7 residential settings. The staffing relief factor reflects the percentage of time an FTE can expect to be absent due to considerations including vacation, holiday, sick leave, and training requirements. This percentage is applied to the total number of "regular" direct care staff needed for a program in order to calculate the number of FTEs necessary ensure that mandated staffing ratios are maintained during staff absences. Relief factors add costs to the rates, but are necessary to provide adequate staffing to ensure safety and foster staff retention.

Management and General
The Management and General (M & G) rate reflects the overhead administrative costs of running a program. This is expressed as a percentage of direct program cost, and typically ranges from 9%-12%. Programmatic requirements, agency size, efficiency, and how administrative costs are allocated across programs can all affect this percentage.

Productivity Factor/ Utilization Factor
Total program costs are divided by total units (e.g. hours or client days) in order to calculate a unit rate. A productivity or utilization factor adjusts the divisor to drive the expectation of the efficient use of resources which are contained in the total projected service cost. For example, total costs can be divided by the total number of expected productive hours for an individual staff person to calculate an hourly rate. This adjustment recognizes that a staff person must be engaged in other activities that are not billable in order to deliver a service. Similarly, a utilization factor may be applied to ensure that total program costs are met if a program meets a specified benchmark of attendance or utilization by dividing total costs by the percentage of program slots that should be filled each day on average.

It is preferable to have data on historical performance – past billings, claims, or time studies—in order to set a productivity or utilization rate. When this is not possible, for example, for programs historically paid through cost reimbursement contracts, EOHHS works with purchasers and consults providers to determine appropriate and reasonable assumptions for efficiently operated providers.

Cost Adjustment Factor
The purpose of a cost adjustment factor (CAF) is to adjust for changes that have occurred or are projected to occur between the year that is the basis of analysis and the year when rates are scheduled to be reviewed anew. For example, if FY2009 UFR and contract budget data was used to develop rates that will be effective in FY2011 and scheduled to be reviewed in FY2013, the CAF brings the FY2009 rate into the prospective rate period.

The specific CAF that is applied to a rate depends on:

- The base year represented by the source data;
- The length of time between the base year and the prospective rate period;
- The most current CAF data available. DHCFP receives updated analyses from IHS Global Insight twice annually.

Geographic Variation
Chapter 257 requires that rates take into consideration geographic differences that result in costs that are substantially higher than the average cost. Although EOHHS analyzes pricing data to identify any statistically significant variation by geographic region, to date, it has been rare to observe statistical significance for those services currently reimbursed under Chapter 257.

PROCESS FOR DEVELOPING AND PROMULGATING RATE REGULATIONS

Many of the new rates are based on Model Budgets, which are developed by a team of staff from purchasing departments, the EOHHS POS Policy Office and the Division of Health Care Finance and Policy (DHCFP). Model budgets may address varying levels of intensity within a specific program, as well as factors described above that may be relevant to a given program.

For all rate development efforts, EOHHS, DHCFP, and purchasing departments have engaged the provider community in an average of two input and dialogue sessions. During these sessions, component analysis is shared and provider input is solicited regarding program intensity and overall structure, potential staffing models, and the relevance and/or influence of the factors described above.

Once all feedback is obtained, rates are developed by DHCFP and reviewed iteratively with purchasing departments. This process culminates in sign off by the Commissioner(s) of the relevant purchasing departments. These proposed rates are presented to the EOHHS Chapter 257 Executive Committee and Secretary for review. Once approved, DHCFP staff develop the draft regulations to implement the rates and initiates the EO 485 process, which ensures coordination within the Executive Branch. After the EOHHS and Executive Office for Administration and Finance approval of the draft regulations, they are then formally proposed by DHCFP, published and a public hearing with comment period is held. Testimony and/or comments are reviewed after the public hearing to determine whether revisions are needed. Upon final review, regulations are adopted, and rates become effective.

III. Rates Established Under Chapter 257 and the Status of Implementation

Chapter 257 requires that EOHHS establish rates of payment for social service programs excluding any program or service which is reimbursable under Medicaid, Title XIX of the Social Security Act. As of December 2010, $201.6M in spending, representing approximately 9.4% of POS spending, has a regulated rate in effect. These services and their current regulations are listed below.

Detailed information on the approved program rates and general rate and services provisions are located at www.mass.gov/dhcfp/regs.

POS Services Currently Reimbursed in Accordance with MGL c 118G

POS Service Class	Dept	MMARS Code	Program Name	C257 Year 1 Spending	Current DHCFP Regulation
Adult Intermediate-Term Transitional	DPH	3386	Residential Treatment	$34,750,584	114.3 CMR 46.00
Adult Short-Term Intervention and Stabilization	DPH	3395	Inpatient Detoxification	$6,687,827	114.3 CMR 46.00
	DPH	4931	Clinically Managed Inpatient Detoxification	$2,443,879	
	DPH	3401	2nd Offender Residential	$220, 028	
	DPH	3434	Transitional Services (TSS)	$8,342,818	
	DPH	3455	Resident Services Women	$360,640	
	DPH	4921*	Statewide Treatment for Civilly-Committed Persons	$2,860,383	
Clinical and Medical Counseling, Therapy, and Treatment	DMH	3050	Contracted Adult Outpatient Services	$185,798	114.3 CMR 6.00
	DPH	3317	Early Intervention – Comprehensive	$22,500,000	114.3 CMR 49.00
	DPH	3385	Ambulatory Services	$3,257,977	114.3 CMR 46.00
	DPH	3397	Narcotic Treatment	$4,219,906	
	DPH	3457	TB Clinics	$956,000	114.3 CMR 8.00
	DPH	3482	Specialized Early Intervention	$1,400,000	114.3 CMR 50.00
Clinical and Medical Diagnostics	DPH	3319	Family Planning Program	$ 4,184,372	114.3 CMR 6.00
Competitive Integrated Employment	MCB	2184	Competitive Integrated Employment	$70,000	114.4 CMR 10.00
	MRC	5100	CIES Hourly Procurement	$7,200,000	114.4 CMR 10.00

POS Services Currently Reimbursed in Accordance with MGL c 118G					
POS Service Class	**Dept**	**MMARS Code**	**Program Name**	**C257 Year 1 Spending**	**Current DHCFP Regulation**
	MRC	5200	CIES Component Procurement	$2,600,000	114.4 CMR 10.00
	DTA	2884	Model 1: Employment Ready	$2,893,452	114.4 CMR 10.00
	DTA	2885	Model 2: Employment Training & Education	$2,956,150	114.4 CMR 10.00
	DTA	2886	Model 3: Employment Supports	$5,039,054	114.4 CMR 10.00
	DTA	2887	Model 4: Enhanced Employment Supports	$1,166,214	114.4 CMR 10.00
	DDS	3180	CIES Hourly Comp. Int. Emp. Svs	$600,000	114.4 CMR 10.00
Direct Prevention, Outreach, Stabilization	DPH	3315	First Offender Driver	$300,000	114.3 CMR 46.00
Family Transitional Support	DPH	3380	Specialized Res Serv	$5,779,388	114.4 CMR 12.00
Placement Services and Supports	DCF	FNFO	Intensive Foster Care	$76,936,522	114.4 CMR 11.00
	DCF	FOS0	Enhanced Therapeutic Foster Care	$775,000	114.4 CMR 11.00
Youth Intermediate-Term Stabilization	DPH	3470	Youth Residential	$3,098,078	114.4 CMR 13.00

* An additional $1.75M of DPH activity code 4921, Statewide Treatment for Civilly-Committed Persons Section 35 Enhancement Rate, is pending EO485 Approval.

In addition to this $201.6M (9.4%) in POS spending that is currently paid under regulations adopted pursuant to Ch 257, projects are underway and/or near completion that will bring an additional $143.1M (6.7%) under regulation. These include:

- **Adult Community Based Support Services:** A regulation that will establish rates of reimbursement for approximately $26.3M in Adult Community Based Support Services purchased by the Department of Developmental Services. These programs help individuals to build and maintain their ability to participate in community activities by focusing on important skill areas that include communication, self-care, relationship building and community involvement. These services are provided by direct care workers in the community and at provider operated facilities.
- **Family Stabilization Services:** A regulation that will establish rates of reimbursement for approximately $43.3M in Family Stabilization Services purchased by the Department of Developmental Services, the Department of Mental Health, and the Massachusetts Commission for the Blind. These programs

provide supports to individuals and families with the purpose of promoting stability, whether this involves preventing out-of-home placement, supporting transition between placements, or independent living.

- **Youth Intermediate-Term Stabilization Services:** A regulation that will establish rates of reimbursement for approximately $40.8M in Youth Intermediate-Term Stabilization Services purchased by the Department of Public Health and the Department of Youth Services. These programs provide a child or youth time-limited overnight housing in a specialized residential or hospital setting to promote stabilization and transition to a less restrictive setting, a permanent family home, independence, or another adult serving program.
- **Family Transitional Support Services:** A regulation that will establish rates of reimbursement for approximately $11.8M in Family Transitional Support Services purchased by the Department of Children and Families and the Department of Public Health. These programs provide families overnight housing in a specialized congregate or individual setting to enable stabilization and transition to a safe, permanent, and self-sufficient home environment.
- **Clubhouse Services:** A regulation that will establish reimbursement for approximately $18.8M in Clubhouse Services purchased by the Department of Mental Health. These programs provide individuals with mental or behavioral health issues support services, including employment, educational and social services to help individuals live productive and stable lives in the community.

IV. Notable Policy and Implementation Challenges

At the outset of the Chapter 257 implementation process, many challenges were anticipated. Over the past year, three principle challenges in particular are most notable. These challenges include:

- Data Availability;
- Alignment with Commonwealth Budget Cycle;
- Unexplained Historical Variation.

CHALLENGE ONE: DATA AVAILABILITY. *Comprehensive information on POS program costs and services is limited. While EOHHS has supplemented the UFR with an array of additional data in the first years of Chapter 257 implementation, a better means for cost reporting is needed.*

Overview and Utility of UFR in Establishing POS Reimbursement Rates

The Uniform Financial Statement and Independent Auditor's Report (UFR) is the annual comprehensive fiscal filing required of most providers engaged in delivery of social and rehabilitative services purchased by Commonwealth departments.

Although the UFR is not the sole resource for determining POS reimbursement rates, it is a principle data source. In particular, the UFR Program Supplemental Information Schedule B presents costs directly associated with individual program operations and provides data on individual program costs and structure. For programs with a history of

a simple unit rate (e.g., per program day, per bed day), the service statistics can provide useful data on productivity and actual utilization of services compared to capacity.

Limitations to Using UFR as Primary Source Data for POS Rate Setting

Although the UFR is an important source of information for understanding POS program operations, the report's utility for establishing POS reimbursement rates is limited. Many providers contend that the report does not demonstrate the "true cost" of providing services, but simply documents how providers spend the revenue they receive.

From the rate development perspective, current program definitions on the UFR do not correspond with the newly-created POS Service Classes, which are intended to serve as a new cross-secretariat organizing framework for grouping similar services. Furthermore, programs with varying service specifications, purchasers, and sites are often co-mingled in the UFR on a single schedule. Missing service statistics or statistics that do not represent a meaningful unit of service are also problematic, and the absence of valid contract identification numbers and activity codes impedes automated data pull efforts, which require time-consuming manual searches.

Strategies to Improve and Supplement the UFR

Governor Patrick convened a Human Services Summit in November 2009 to discuss how state government, non-profit human services organizations, and the private sector might work together to support a progressive human services agenda. One recommendation was to examine options for modifying the UFR to provide a better basis for determining the cost of POS programs and services. As a result, a cross-Secretariat working group was established to recommend changes that may address some of these limitations. Over the past several months, this working group has reviewed the utility of the UFR and worked with provider organizations to explore solutions that support cost effective, program focused financial audit of POS providers, cost analysis for rate development, and programmatic review.

While these recommendations are under development, EOHHS supplements the UFR with many other data sources. Purchasing departments help to specify the necessary staffing levels and intensities for each program. In several recent projects, rates have been developed using contract budgets that reflect more current cost data and recent programmatic change. DHCFP staff have also conducted provider surveys to capture data on how programs are structured, descriptions of residential buildings, and details on use of funding for program components such as transportation. In addition, rate development regularly incorporates public data sources such as national organization surveys, the U.S. Bureau of Labor Statistics, the U.S. Department of Housing and Urban Development, and other sources.

Provider input is also an essential source of information in this area. On average, EOHHS facilitates at least two provider forums per Service Class. Additionally, in certain circumstances smaller technical advisory groups have been formed to provide more in-depth technical advisement. These sessions allow for greater depth in understanding core program components, cost drivers, and procurement considerations.

CHALLENGE TWO: ALIGNMENT WITH COMMONWEALTH BUDGET CYCLE. *The timeline for implementation specified in Chapter 257 is not aligned with the Commonwealth budget development cycle. When pricing analyses warrant overall increases in reimbursement rates, there is no mechanism to address the financial impact in the budget development cycle.*

> ***Case illustration: DYS Youth Intermediate-Term Stabilization Services***
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> The Department of Youth Services (DYS) spends approximately $39.4M annually on programs in this Service Class. These include the Secure Treatment, Group Care, Revocation, and Transitional Independent Living programs. All DYS programs in this class provide security, behavior management, clinical, health, education, recreation, family support, facility operation and community transition services with the goal of reducing risk and preparing youth to transition to the community. The specific programs differ in intensity and combination of their components depending on the population served by each.

Overview of Data Analyses and Cost Drivers for Existing DYS Programs

DYS, DHCFP, and EOHHS project team staff assessed a number of data sources to develop rates for DYS Youth Intermediate-Term Stabilization Services. Although FY2009 UFR data for these DYS programs was reviewed, DHCFP and DYS selected FY2010 contract budgets as the baseline for analysis, as these provided more current information on FTEs, salary levels, and current program costs. DYS contract records on program utilization rates and facility ownership status also served as primary data, as did input from working sessions with DYS staff and personnel from provider organizations.

Currently, among the 26 DYS programs in this service class, rates range from $201 - $342 per youth, per day. The largest number of programs is reimbursed at $250 - $300 per youth, per day. The primary cost categories for program budgets include salaries (56.6%), taxes and fringe benefits (14.6%), general and administrative costs (11.2%), occupancy expenses (8.8%) and other program expenses (8.3%).

The weighted average salary for Direct Care positions is $27,749. Average salaries do not differ by geographic region. Beyond FTE ratios and salaries, critical elements in the pricing analysis involve whether facilities are leased or owned and the rate of program utilization. DYS does not have control over its client volume, so providers must maintain a basic level of available capacity. Therefore, a "utilization factor" adjusts the reimbursement rate accordingly. Additional detail on the construction of the draft DYS rates is in the Appendix.

From a detailed review of current, published DYS program requirements, the team developed benchmark Direct Care staff-to-client ratios. Comparison of these program specifications to actual contract budgets revealed that that the benchmark ratios are more intensive than what is supported in the current budgets. This comparison revealed that many existing programs, especially the smaller capacity programs, do not have adequate staffing to meet current DYS requirements.

In addition, DYS contracts currently specify a target relief percentage of 14% for Direct Care FTEs. No contract budgets reflect this level of relief support, and DYS has determined that 14% itself provides inadequate coverage for staff sick, personal, vacation, holiday, and training hours as well as unscheduled but recurring safety or security needs. This point was also heard extensively from the provider community. DYS, therefore, recommended a Direct Care relief percentage of 19.6%.

Comparison to other Services in the Service Class

One of the policy objectives of Chapter 257 is to increase transparency in rate setting and to ensure standard reimbursement for similar programs. Like DYS, the Department of Children and Families (DCF) and the Department of Mental Health (DMH) also purchase programs that have been categorized into the Youth Intermediate-Term Stabilization Service Class. Rate development projects are also underway for these services, leading EOHHS to examine how the DYS program costs compare with other similar programs and services.

This review of other programs in the Youth Immediate-Term Stabilization Class showed that in most cases, reimbursement rates for programs purchased by DCF and/or DMH are significantly higher than DYS reimbursement rates.

Current Daily Rate	FY10 DYS	FY09 DCF	FY09 DMH
Mean	$265	$288	$364
Minimum	$201	$222	$173
Maximum	$342	$355	$453

A comparison of FY2009 UFR data for similar DYS, DCF, and DMH programs showed that DYS has less intensive Clinical / Direct Care staffing ratios than DCF and DMH although the DYS population is at least as acute as the populations served by DCF and DMH. In addition, many youth served in DYS programs enter the juvenile justice system after being served by DCF and DMH.

	Non-Specialized Direct Care Staff Ratios			Clinical Staff Ratios		
	DYS	DCF	DMH	DYS	DCF	DMH
Average	0.95	0.69	0.73	12.18	9.14	7.28
Low	1.78	.97	1.35	0	0	16.00
High	0.61	0.49	0.54	5.77	3.80	4.10

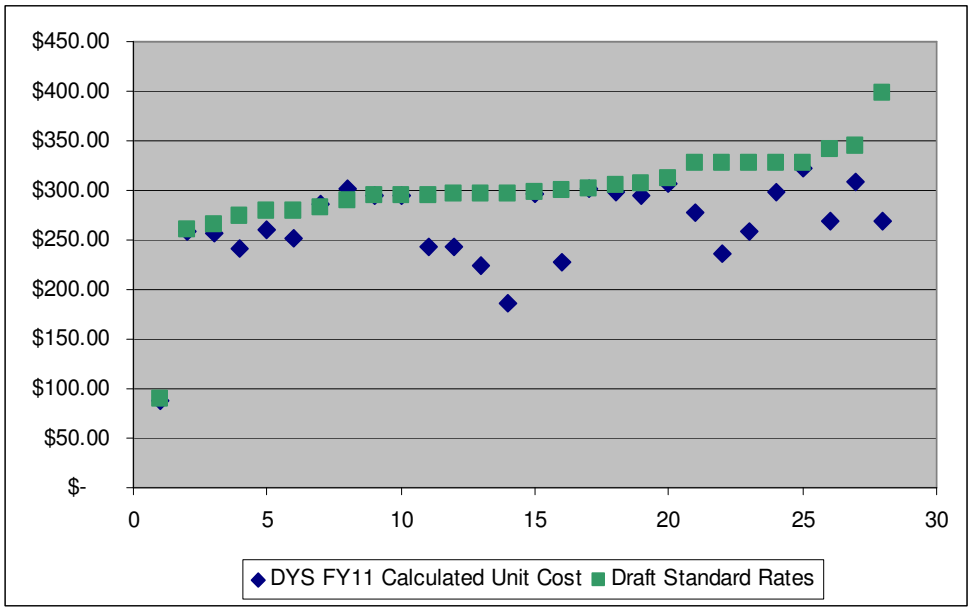
* Ratios reflect clients per FTE. Ratios lower than 1.0 reflect the fact that multiple FTEs are needed to cover 24/7 shifts. Outliers excluded. Programs indicating zero clinical staff may have been operating under position vacancies or may have miss-classified clinical staff.

Draft Rate Structure for DYS Programs

Based on the analysis of cost data and on the comparison of programs in the same Service Class across departments, project team staff developed a series of model budgets that correspond to five capacity levels, ranging from 12- to 30-bed programs. The model budgets vary primarily on program capacity levels and corresponding staffing intensity, as well as occupancy status and utilization factors.

Anticipated Fiscal Impact of Chapter 257 Proposed Rates

After factoring in modest salary levels, occupancy expense amounts, and cost adjustment factors, the proposed model budgets result in higher payment rates for the majority of existing providers. This is largely due to the increase of Direct Care ratios and Clinical staffing levels necessary to meet program and staffing requirements.



The DYS example is an illustration of what has been encountered on other current rate regulation projects under Chapter 257. Implementation of these regulations requires additional funding. However, given the timeline specified in Chapter 257, the Commonwealth is not afforded the opportunity within the budget cycle to assess this impact and build an appropriate budget response. A better process to align the Chapter 257 implementation timeframe with the Commonwealth budgeting cycle is needed to respond to situations where analysis supports an increase in historical reimbursement rates.

CHALLENGE THREE: UNEXPLAINED HISTORICAL VARIATION. *In many cases, reimbursement rates are the result of long-term contracts and individual negotiations between purchasing departments and providers. This results in variation in rates that is not "explained" by identifiable differences in programs. Standardizing on cost-based rates in these cases may result in significant increases or decrease in revenue for many providers.*

> ***Case illustration: DDS Community Based Day Supports***
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> The Department of Developmental Services (DDS) Community Based Day Supports (CBDS) are programs that help individuals build and maintain their ability to participate in community activities by focusing on important skill areas that include communication, self-care, relationship building and community involvement. DDS invests over $26.3M in contracts that fund Direct Care workers in the community and at provider-operated facilities.

Overview of Data Analyses and Cost Drivers for DDS Community Based Day Supports

DDS currently purchases Community Based Day Support (CBDS) services through 104 individually negotiated contracts with 67 providers. Rates for these services range from $33 - $331 per client, per day. DHCFP staff analyzed all program contracts in an effort to understand what drives this variability in payment rates. In particular, the analysis looked for differences in staff salary, program location, capacity, occupancy costs, and staffing intensity that might explain this variation.

The POS Project team staff relied on FY2008 UFR data at the outset of this effort. However, as in the case of the DYS example, FY2010 DDS contract data was selected as the baseline for analysis since UFR submissions often co-mingled other programs with CBDS filings. DDS also conducted a provider survey to validate service units and engaged field staff throughout the process to better understand program operations and contract data. To date, DDS, EOHHS, and DHCFP have facilitated four technical advisory group sessions with providers to gain insight into the CBDS program and rate variability, as well as to discuss potential rate structures.

After multiple iterations of analysis and ongoing work to improve and develop strong data sources, EOHHS is not able to identify a statistically based explanation in the cost data for the variation in payment rates for these services. Although Direct Care staffing ratios go furthest in predicting variation in costs, a great deal of variation remains that is not explained by staffing intensity. Average salary levels do not consistently explain these differences, and occupancy costs are especially variable among programs. Furthermore, neither occupancy costs nor any of the other non-personnel costs vary significantly by program intensity, capacity, or geographic location.

Draft Rate Structure for DDS CBDS Programs

Absent a clear statistical explanation for the variation in current rates of reimbursement, project team staff constructed model budgets for programs that are based on varying levels of Direct Care staffing intensity. The draft rates correspond with seven levels of intensity that support clients who need a 1 : 1 to 1 : 10 FTE to client ratio.

Intensity Level Direct Care: Client	Number of Contracts	Current Unit Rate Range*	Proposed Unit Target Rate
1:1	11	$156 - $321	$235.98
1:2	24	$91 - $171	$132.79
1:3	25	$61 - $118	$95.38
1:4	21	$38 - $108	$79.05
1:5	8	$48 - $75	$69.96
1:6	6	$48 - $86	$57.00
1:7+	9	$39 - $80	$45.64

*Excludes outliers.

As shown in the table above, current rates vary within and across the designated intensity levels. Standardizing on the proposed set of seven rates will impact the revenue of many programs. EOHHS estimates that the draft set of seven target rates will result in 50% of programs gaining revenue with an average projected gain of approximately 25% and 50% of programs losing revenue with an average projected loss of 17%.

Depending on how the rates are implemented, the proposed rate structure could require an additional funding investment for a transitional period. While a transitional implementation timeframe would provide significant relief for those programs projected to experience revenue loss under the target rates, additional funding is not supported within the FY2011 DDS Day and Employment Services funding level, account areas, which have already experienced significant reductions in recent months.

V. Potential Strategies to Address These Challenges

As these and the other Chapter 257 rate setting projects near completion, proposed rate regulations will be developed and released for public comment. As the Year 2 rate regulation proposal process proceeds, EOHHS will explore multiple strategies to mitigate the impact of the challenges described in this report.

Three potential strategies are discussed below. None is a "silver bullet," but together or in combination, they may provide relief against the multiple unintended policy outcomes of the new law. Some of the advantages and limitations for three approaches are discussed below.

Option One: Promulgate Regulations with Delayed Payment Rate Effective Dates

Even outside the fiscal pressure presented by Chapter 257 implementation, the Commonwealth faces significant budget reductions for FY2011 that likely will remain unchanged through FY2012. This fiscal reality limits EOHHS' ability to reassign existing resources to fund proposed reimbursement rates while meeting the Secretariat's obligation to preserve safety net and critical services for vulnerable populations.

Absent the availability of new funding for services, EOHHS may in some cases elect to promulgate regulated rates with a delayed effective date. This option provides the opportunity for funding needs to be addressed in the Commonwealth's annual spending plan development. In addition, where procurement is warranted, this delayed effective date would ensure that both providers and departments have complete information regarding adopted rates in advance of procuring services.

Option Two: Develop Rate Models with Multi-Year Transition-to-Target Features

In cases where implementing regulated rates would result in significant revenue fluctuations for some provider organizations, a transition approach may be used. Under such an approach, providers projected to gain or lose more than a certain percentage of current revenue would receive the target rates adjusted by an index factor that spreads the impact of these changes over two to three years. While this methodology will not eliminate the negative financial impact to providers, it extends time to provider organizations to plan for change while maintaining integrity with the data analysis in which current variation in rates is not explained.

Option Three: Modify the Chapter 257 Statute

As the current economic climate makes it difficult to support even modest rate increases within the statutorily required timeline, a final option for consideration is recommending to the legislature an amendment to Chapter 257 to allow a delay in implementation by fifteen months. This modification has several benefits. It would not only better align implementation of the statute with the Commonwealth budget and spending plan development cycles, but also with procurement activity so that pricing and rate adoption could be completed in advance of conducting a procurement. Furthermore, this delay would allow EOHHS, and the provider community to engage in efforts to modify the UFR to better support pricing analysis and rate development.

Gov. Patrick has proposed legislation (Section 18 of his January 2011 supplemental budget, H. 37) to delay the Ch. 257 deadlines. Provider organizations support this legislation because (at their request) it also delays related procurements until the Ch. 257 rates are set, with certain exceptions. This is the Governor's preferred solution and the language was included in the recently signed Supplemental budget, now Chapter 9 of the Acts of 2011.

VI. Conclusion and Next Steps

The Patrick-Murray Administration remains committed to upholding its obligations under Chapter 257, while at the same time balancing its commitment under a variety of mandates. As a result, EOHHS has been working to implement Chapter 257 in a budget neutral manner, exploring options to increase reimbursement rates where required by shifting resources or decreasing service volume. However, as the data within these case illustrations suggests, this approach is not always practicable.

We look forward to continued collaboration with both the Legislature and with provider organizations as we explore implementation options to advance the policy objectives of this law.